TEXT OF REGULATIONS

Subarticle 2: Risk-Bearing Organizations

1300.75.4 Definitions
1300.75.4.1 Risk ~~Sharing~~ Arrangement Disclosure
~~1300.75.4.2 Organization Criteria~~
1300.75.4.2 ~~1300.75.4.3~~ Organization Information
~~1300.75.4.4 Organization Evaluation~~
~~1300.75.4.5 Corrective Action~~
1300.75.4.3 ~~1300.75.4.6~~ Plan Reporting
1300.75.4.4 Confidentiality
1300.75.4.5 ~~1300.75.4.7~~ Plan Compliance
1300.75.4.6 ~~1300.75.4.8~~ Department Costs

TEXT OF PROPOSED CHANGES
TO THE REGULATIONS UNDER THE
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

1. Adopt Subarticle 2 (commencing with Section 1300.75.4) to Article 9 of Subchapter 5.5 of Chapter 3 of Title 10, California Code of Regulations, to read:

Subarticle 2: Risk-Bearing Organizations

1300.75.4. Definitions.

(a) As used in this subarticle:

~~(1) "Corrective action plan" means a document with terms and conditions for correcting, and monitoring an organization's efforts to correct, any of the following:~~

~~(A) Any repeated failure to reimburse, contest, or deny claims, or to estimate or document incurred but unreported claims, in accordance with Rule 1300.75.4.2, with a frequency which evidences a business practice or course of conduct.~~

~~(B) Any failure to maintain, at all times, minimum tangible net equity or minimum working capital, in accordance with Rule 1300.75.4.2.~~

(1 ~~2~~) "External party" means the Department of Managed Health Care or its designated agent, which may be an outside entity or person contracted or appointed to fulfill the functions stated in these regulations. Whenever these regulations reference the Department of Managed Health Care, that reference means the Department of Managed Health Care or its designated agent, which may be an outside entity or person contracted by the Department of Managed Health Care to fulfill the stated function. ~~an independent review entity that administers a process for reviewing or grading organizations and a process for corrective action plans, pursuant~~

~~to a contract with the Department which provides for an objective evaluation, preserves the confidentiality of proprietary information, and prevents conflicts of interest with the plan or organization.~~

(~~3~~ 2) "Organization" means a risk-bearing organization as defined in subdivision (g) of Section 1375.4 of the Code.

~~(4) "Proprietary information" means information that must be kept confidential to avoid an adverse affect on the integrity of the contract negotiation process between a plan and an organization, as determined by the external party.~~

Note: See Section 1300.75.4.5 for confidentiality treatment.

(~~5~~ 3) "Risk arrangement" shall include both "risk-sharing arrangement" and "risk-shifting arrangement," which are defined as follows:

(A) "Risk-sharing arrangement" means any compensation arrangement between an organization and a plan ~~that may directly or indirectly have the effect of reducing or limiting health care services to enrollees~~ under which both the organization and the plan share a risk of financial loss.

(B) "Risk-shifting arrangement" means a contractual arrangement between an organization and a plan under which the plan pays the organization on a fixed, periodic or capitated basis, and the financial risk of the arrangement is assumed by the organization.

(b) For purposes of subdivision (g) of Section 1375.4, the term "lawfully organized group of physicians" means a medical group, independent practice association, or other entity that delivers, furnishes, or otherwise arranges or provides health care services, ~~including a licensed health facility,~~ but excluding an individual or plan, and excluding any entity barred from

the practice of medicine by California Business & Professions Code Section 2400 or a successor provision to California Business & Professions Code Section 2400.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.1. Risk ~~Sharing~~ Arrangement Disclosure.

(a) Every contract involving a risk arrangement between a plan and an organization shall require the plan to do all of the following:

(1) Disclose in writing (or through electronic transmission, if agreeable to both the organization and the plan) to the organization, on a monthly basis, beginning with the month of April, 2001, within 10 calendar days of the end of each report month, the following information for each enrollee assigned to the organization: name, ~~age~~ birth date, gender, zip code of residence, plan contract selected, any other third party coverage, enrollment/disenrollment dates, medical group/IPA number, provider effective date, type of change to coverage, co-payment, deductible, and the primary care physician when the selection of a primary care physician is required by the plan or identified to the plan.

(2) Disclose in writing (or through electronic transmission, if agreeable to both the organization and the plan) to the organization, on a monthly basis, beginning with the month of April, 2001, within 10 calendar days of the end of each report month, the names and total numbers of enrollees added or terminated under each plan contract served by the organization.

(3) Disclose, as part of the contract with the organization, the following information for each and every risk ~~sharing~~ arrangement under the contract:

(A) the nature of the risk-~~sharing~~ arrangement; the purpose of the risk-~~sharing~~ arrangement; ~~the method for determining each and every amount (including expenses and income) allocated to the organization and to the plan under the risk-sharing arrangement; a separate explanation of the method of calculating each and every amount allocated to the organization and to the plan for the provision of any pharmacy services under the risk-sharing arrangement;~~ and the time period for the risk-sharing arrangement;

(B) identification through a matrix of responsibility of the medical expense categories (physician, institutional, and pharmacy) which will be allocated to the organization, the plan, the hospital and the enrollee under the risk-~~sharing~~ arrangement; the source of the data and the actuarial methods employed in determining the rates, including the utilization and unit cost actuarial assumptions by expense category used to determine the reimbursement to the organization for the risk arrangement;

(C) factors used for any adjustments from the actuarial assumptions, factors for point of service out of network service utilization, and any applied age/sex or geographic factors; and

(D) for any risk-sharing arrangements, the actuarial assumptions of utilization and unit cost of service along with any factors such as age/sex.

(4) Disclose in writing (or through electronic transmission, if agreeable to both the organization and the plan) to the organization, on a quarterly basis, within 120 calendar days of the close of each quarter, a detailed description of each and every amount (including expenses and income) allocated to the organization and to the plan under each and every risk-~~sharing~~ arrangement.

(5) Provide payments of all risk-~~sharing~~ arrangements, excluding capitation, no later

than 180 days after the close of the organization's ~~fiscal~~ contract year, or the contract termination date, whichever occurs first.

(b) In addition to the disclosures required by subsection (a) of this rule, every contract involving a risk arrangement between a plan and an organization shall require the plan to disclose, as part of the contract, the amount of payment for each and every service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each and every service and, in the case of capitated payment, the amount to be paid per enrollee per month. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract may incorporate that fee schedule by reference. For any proprietary fee schedule, the contract must include sufficient detail that payment amounts related to that fee schedule can be accurately predicted. For any deductions which the plan may take from any capitation payment, details regarding each deduction shall be provided.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

~~**1300.75.4.2. Organization Criteria**.~~

~~(a) Every contract involving a risk arrangement between a plan and an organization, that is issued, amended, renewed, or delivered in this state on or after the January 1, 2001, shall require the organization to do all of the following:~~

~~(1) Reimburse, contest, or deny at least 95% of all every claims for health care services it has provided, arranged for, or for which it is otherwise financially responsible for in accordance with the timeframes and other requirements described in Sections 1371 and 1371.35 of the Code, and in accordance with any other applicable state and federal laws and regulations.~~

~~(2) Estimate its liability for incurred but not unreported (IBNR) claims on a monthly basis pursuant to a "lag study" method as defined and illustrated in Rule 1300.77.2(c) or an "actuarial estimate" method as defined and specified in Rule 1300.77.2(d), and document this estimate at least quarterly as an accrual in its books and records, and document this accrual in all of its financial statements.~~

~~(3) Maintain at all times a positive tangible net equity, as defined in Rule 1300.76(e), of at least fifty thousand dollars ($50,000).~~

~~(4) Maintain at all times a positive level of working capital, calculated in a manner consistent with generally accepted accounting principles (GAAP). comprised of liquid assets of at least twenty-five thousand dollars ($25,000) in excess of current liabilities. "Liquid assets" means cash or securities specified as cash "equivalents" in Rule 1300.77(b) deposited with any bank authorized to do business in this state and insured by the Federal Deposit Insurance Corporation.~~

~~(b) An risk-bearing organization may reduce its liabilities for purposes of calculating its tangible net equity and working capital in a manner allowed by Section 1375.4(b)(1)(B) of the Code. For purposes of Section 1375.4(b)(1)(B) of the Code, a sponsoring organization shall have a tangible net equity of at least 10 million dollars ($10,000,000) in excess twice the total of all amounts that it has guaranteed to any person or entity, or a tangible net equity in an amount approved by the Director.~~

~~NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.~~

1300.75.4.2. ~~1300.75.4.3.~~ Organization Information.

Every contract involving a risk arrangement between a plan and an organization shall require the organization to do all of the following:

(a) Beginning with the first quarter of the 2001 calendar year (first submission due by May 15, 2001), ~~S~~submit to the ~~external party~~ Department of Managed Health Care or its designated agent, in a form and manner determined by the Department, not more than forty-five (45) days after the close of each quarter of the fiscal year, a quarterly status report containing all of the following:

(1) Financial statements (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures), or comparable financial statements in the case of a nonprofit entity, for the immediately preceding quarter prepared in accordance with generally accepted accounting principles (GAAP).

(2) A statement as to what percentage of claims received during that quarter have been ~~whether or not the organization has~~ reimbursed, contested, or denied ~~all claims received~~ by the organization ~~during the quarter~~, in accordance with the timeframes and other requirements described in California Health and Safety Code Sections 1371 and 1371.35, and in accordance with any other applicable state and federal laws and regulations. ~~Rule 1300.75.4.2.~~ If less than 95% of all claims received during the quarter have ~~any claim has not~~ been reimbursed, contested or denied on a timely basis, ~~as required by that rule,~~ the statement shall be accompanied by a report that describes ~~the following with respect to each deficient claim: claim number, date of receipt, contracting plan, name of the claimant, claim amount,~~ the reasons why the claims-paying process is not meeting the requirements of applicable law, any action taken to correct the deficiency, and any results of that action.

(3) A statement as to whether or not the organization has estimated and documented, on a monthly basis, its liability for incurred but not ~~un~~reported (IBNR) claims received during the quarter, pursuant to a method specified in Rule 1300.77.2, and that these estimates are the basis for the financial statements submitted under these Rules. ~~in accordance with Rule 1300.75.4.2.~~ If the estimated and documented liability has not met the requirements of Rule 1300.77.2 ~~the rule~~ in any way, the statement shall be accompanied by a report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

Option 1:

(4) (A) A statement as to whether or not the organization has at all times during the quarter maintained a positive tangible net equity ("TNE"), as defined in Rule 1300.76(e); and positive level of working capital, calculated in a manner consistent with generally accepted accounting principles (GAAP). ~~as required by Rule 1300.75.4.2.~~ If the required TNE or working capital have not been maintained at all times, the statement shall be accompanied by a report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(B) The organization may reduce its liabilities for purposes of calculating its tangible net equity and working capital in a manner allowed by Health and Safety Code Section 1375.4(b)(1)(B). For purposes of Health and Safety Code Section 1375.4(b)(1)(B), a sponsoring organization shall have a tangible net equity of at least twice the total of all amounts that it has guaranteed to all persons or entities, or a tangible net equity in an amount approved by the Director of the Department of Managed Health Care.

Option 2:

(4) (A) A statement as to whether or not the organization has at all times during the quarter maintained a positive tangible net equity ("TNE"), as defined in Rule 1300.76(e); and positive level of working capital, calculated in a manner consistent with generally accepted accounting principles (GAAP). ~~as required by Rule 1300.75.4.2.~~ If the required TNE or working capital have not been maintained at all times, the statement shall be accompanied by a report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(B) The organization may reduce its liabilities for purposes of calculating its tangible net equity and working capital in a manner allowed by Health and Safety Code Section 1375.4(b)(1)(B). For purposes of Health and Safety Code Section 1375.4(b)(1)(B), a sponsoring organization shall have a tangible net equity of at least twice the total of all amounts that it has guaranteed to all persons or entities, or a tangible net equity in an amount approved by the Director of the Department of Managed Health Care.

(C) For purposes of subparagraph 4(A), “at all times” means, at a minimum, on a consistent basis, and at all times when any internal financial statement is generated or produced.

(5) A written verification attached to each report made under paragraphs (1), (2), (3) and (4) of this subsection stating that the report is true and correct to the best knowledge and belief of the principal officer of the organization, and signed by the principal officer.

(b) Submit to the ~~external party~~ Department of Managed Health Care or its designated agent, in a form and manner determined by the Department, not more than one

hundred eighty (180 days) after the close of the fiscal year beginning in year 2000, and not more than one hundred twenty (120) days after the close of ~~the~~ each fiscal year beginning in year 2001 and following years, an audit report prepared by an independent certified public accountant in accordance with generally accepted auditing standards (or governmental auditing standards in the case of a public entity), containing all of the following:

(1) Financial statements (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures), or comparable financial statements in the case of a nonprofit entity, for the immediately preceding fiscal year, prepared by the independent certified public accountant in accordance with generally accepted accounting principles (GAAP). For purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, Sections 1 through 99.2, Title 16, California Code of Regulations), shall apply.

~~(2) A verification of whether or not the information submitted to the external party Department of Managed Health Care by the organization pursuant to paragraph (2) of subsection (a) of this rule is accurate or inaccurate based on the accountant's review of a random sampling of claims selected by the accountant.~~

~~(3) A verification of whether or not the information submitted to the external party Department of Managed Health Care by the organization pursuant to paragraph (3) of subsection (a) of this rule is accurate or inaccurate, based on the accountant's review of the information used by the organization to support its estimated liability, document its estimate as an accrual in books and records, and document this accrual in its financial statements.~~

~~(4) A verification of whether or not the information submitted to the external party Department of Managed Health Care by the organization pursuant to paragraph (4) of subsection~~

~~(a) of this rule is accurate or inaccurate, based on the accountant's review of the information used by the organization to prepare its quarterly financial statements.~~

~~(5) A report of any inaccuracies noted by the accountant with respect to the reviews conducted under paragraphs (2), (3), and (4), of this subsection, containing, for each inaccuracy, a description of the inaccuracy, the reasons for the inaccuracy, any action taken to address the inaccuracy, and any results of that action.~~

(2 ~~6~~) An opinion of the accountant indicating that the financial statements present fairly, in all material respects, the financial position of the organization, and that the financial statements were prepared in accordance with generally accepted accounting principles (GAAP). With this opinion of the accountant, there must be included a redacted copy of the audit management letter including all portions of the management letter related to the organization's financial solvency.

(3) A "Statement of Organization," to be filed with the initial filing on or before May 15, 2001, and with each subsequent annual filing, which shall include the following information:

(A) Name and Address of the Risk-Bearing Organization;

(B) Contact Person, with Name, Title, Address, Phone, Fax, and e-mail address;

(C) All Health Plans with which the risk-bearing organization has contracts;

(D) Whether the Organization is an Independent Physician Association, Medical Group, or both;

(E) All other medical providers, including hospitals, pharmacy companies, laboratories, practitioners, etc., with which the risk-bearing organization has contracts.

(F) An approximation of the Number of Enrollees, pursuant to a list of ranges developed by the Department;

(G) Any Management Services Organization (MSO) that the risk-bearing organization contracts with for administrative services;

(H) List of Primary Care Physicians, with name, address, phone, and fax for each;

(I) Description of Geographic Area Serviced by the risk-bearing organization;

(J) List of Affiliated Hospitals, with name, address, phone, and fax for each;

(K) Any other information which the Director deems reasonable and necessary.

~~(c) Provide written notice to the external party Department of Managed Health Care within thirty (30) days after the engagement of any new independent certified public accountant that will prepare the annual audit report and financial statements required by subsection (b) of this rule. The written notice shall state whether there was any disagreement with the former accountant on any matter in connection with the preparation of the most recent audit report or financial statements reported upon by the accountant. If there was any disagreement, the written notice shall describe the reasons for the disagreement. The written notice shall be signed by the principal officer of the organization. In addition, the organization shall request, in writing, the former accountant to furnish the organization with a written response stating whether the former accountant agrees with the statements contained in the organization's written notice. If the former accountant disagrees with any of the organization's statements, the former accountant's letter shall explain the reasons for disagreeing with the organization's statements. The former accountant's letter shall be submitted with the written notice.~~

(~~d~~ c) Notify the ~~external party~~ Department of Managed Health Care or its designated agent no later than ~~one (1)~~ five (5) business days from discovering that the organization has experienced any event which might materially alter its financial situation, or threaten its solvency. Examples might include, but are not limited to, the loss of enrollees represented by a

major employer; a substantial overpayment by a health plan which is re-claimed by that health plan; and any other event which would materially alter the organization's financial situation.

~~.allowed: (1) any repeated failure to reimburse, contest, or deny claims, or to estimate or document incurred but unreported claims, in accordance with Rule 1300.75.4.2, or (2) any failure to maintain, at all times, minimum TNE or minimum working capital, in accordance with Rule 1300.75.4.2~~.

(~~e~~ d) Permit the ~~external party~~ Department of Managed Health Care or its designated agent to make any examination that it deems reasonable and necessary to determine whether the organization is meeting the criteria of Health and Safety Code Section 1375.4(b)(1)(A)(i), (ii), (iii), and (iv), ~~Rule 1300.75.4.2,~~ and provide to the ~~external party~~ Department, upon request, any books or records that the ~~external party~~ Department deems relevant for inspection and copying.

~~(f) Allow the plan to terminate the contract if the organization has failed to provide the reports or notices, or has failed to permit an examination by the external party, as required by this rule.~~

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

~~**1300.75.4.4. Organization Evaluation.**~~

~~(a) Every contract between a plan and an organization shall require the organization to comply with a process administered by the external party to review or grade the organization. The contract shall also require the organization, as part of this process, to do all of the following:~~

~~(1) Permit the external party to perform any of the following activities:~~

~~(A) Obtain and evaluate information pertaining to the organization's performance in meeting the criteria of Rule 1300.75.4.2.~~

~~(B) Prepare periodic reports describing the organization's overall performance in meeting the criteria of Rule 1300.75.4.2 and comparing the overall performance of all organizations.~~

~~(C) Maintain a public file of reports and nonproprietary information concerning the organization and make the reports and information available to plans, organizations, the Department, and other interested parties.~~

~~(2) Allow the plan to terminate the contract if the organization has failed to comply with the evaluation process or has failed to permit the activities of the external party, as required by this subsection.~~

Note: Portions of the following subsection (b) have been moved to a new subsection (d) of the next section.

~~(b) Every plan that contracts with an organization shall have adequate procedures in place to ensure that the plan:~~

~~(1) Reviews any reports and nonproprietary information made available by the external party, to determine whether or not all of the plan's organizations are meeting the criteria of Rule 1300.75.4.2.~~

~~(2) Notifies the external party no later than one (1) business day from discovering that any of its organizations have allowed (A) any repeated failure to reimburse, contest, or deny claims, or to estimate incurred but unreported claims, in accordance with Rule 1300.75.4.2, or (B) any failure to maintain, at all times, minimum tangible net equity or minimum working capital, in accordance with Rule 1300.75.4.2.~~

~~NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.~~

~~1300.75.4.5. Corrective Action~~

~~(a) Every contract between a plan and an organization shall require the plan and the organization to comply with a process administered by the external party for corrective action plans. The contract shall also require the plan and the organization, as part of this process, to do all of the following:~~

~~(1) Propose recommendations for corrective action upon request of the external party.~~

~~(2) Meet with and advise the external party regarding the recommended corrective action, upon request of the external party.~~

~~(3) Permit the external party to prepare a corrective action plan, taking into consideration the recommendations of the plan and the organization.~~

~~(4) Resolve any disputes concerning the corrective action plan pursuant to a resolution mechanism established by the external party.~~

~~(5) Allow the Director up to five (5) business days from receipt of the corrective action plan from the external party (or longer period if deemed necessary by the Director), to inform the external party that the corrective action plan is either approved without modifications or approved subject to any modifications, including standardization, that the Director deems appropriate to meet the needs of the Director and all plans contracting with the organization.~~

~~(6) Terminate the contract if the organization has failed to comply with the corrective action process, or if the organization has failed to take corrective action or to meet the requirements of Rule 1300.75.4.2 in accordance with the approved corrective action plan.~~

~~(7) Adhere to any contingency plan (as set forth in the approved corrective action plan) for the continuous delivery of health care services to the plan's enrollees, if the organization's corrective action fails.~~

~~(b) Every plan that contracts with an organization shall have adequate procedures in place to assure that the plan complies with the corrective action process and cooperates in the implementation of an approved corrective action plan.~~

~~NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.~~

~~1300.75.4.6~~ 1300.75.4.3. Plan Reporting.

(a) Every plan that contracts with a~~n~~ risk-bearing organization shall, by April 1, 2001, for the fourth quarter of calendar year 2000, and not more than forty-five (45) days after the close of each subsequent quarter, ~~of its fiscal year~~, submit a report to the Director, in a form and manner determined by the Department of Managed Health Care, containing a list of all its contracting organizations including their names, addresses, contact persons, and telephone numbers, and describing all risk-~~sharing~~ arrangements with each organization in a manner that enables the Director to determine the type and amount of financial risk assumed by each organization including, at a minimum, the following information for each and every risk-~~sharing~~ arrangement:

(1) The nature of the risk-~~sharing~~ arrangement.

(2) The purpose of the risk-~~sharing~~ arrangement.

(3) The method for determining each and every amount (including expenses and income) allocated to the organization and to the plan under the risk-sharing arrangement.

(4) A separate explanation of the method of calculating each and every amount allocated to the organization and to the plan for the provision of any pharmacy services under the risk~~-sharing~~ arrangement.

(5) The time period for the risk~~-sharing~~ arrangement.

(6) Each and every amount allocated to the organization and to the plan under the risk~~-sharing~~ arrangement.

(7) Any problem experienced by either the plan or the organization with respect to the risk~~-sharing~~ arrangement and, for each problem, a description of any action taken to correct that problem together with an explanation of the results of that action.

(b) Each quarterly report shall specify the plan's name, the quarter and date of report. In addition each quarterly report shall be signed by a person authorized to do so by the plan, verified, and filed along with two copies of the report, in the Department's Sacramento Office to the attention of the Health Plan Filing Clerk. The quarterly report need not be filed as an amendment to the plan application.

(c) Upon request, the plan shall provide any additional information that the Director may from time to time require to understand the type, amount, or appropriateness, of the financial risk assumed by the plan's organizations.

Note: The following subsection (d) includes some portions of the former subsection 1300.75.4.4(b) (the remainder of old section 1300.75.4.4 has been deleted).

(d) Every plan that contracts with an organization shall have adequate procedures in place to ensure that the plan notifies the Department of Managed Health Care or its

designated agent no later than ~~one (1)~~ five (5) business days from discovering that any of its organizations experienced any event which might materially alter the organization's financial situation, or threaten its solvency. Examples might include, but are not limited to, the loss of enrollees represented by a major employer; a substantial overpayment by a health plan which is re-claimed by that health plan; and any other event which would materially alter the organization's financial situation.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.4. Confidentiality.

The Director shall provide for the confidentiality of financial and other records to be produced, disclosed, or otherwise made available pursuant to Health and Safety Code Section 1375.4, and to these regulations, unless the Director determines otherwise.

Note: This confidentiality language replaces the former definition of "proprietary information," which has been deleted.

NOTE: Authority cited: Sections 1344, 1375.4(b)(7), and 1375.4, Health and Safety Code. Reference: Sections 1375.4 and 1375.4(b)(7), Health and Safety Code.

~~**1300.75.4.7**~~ **1300.75.4.5. Plan Compliance**.

~~(a) A plan that complies with all provisions of this subarticle with respect to a contract with an organization shall be deemed to have satisfied its obligations under Rule 1300.70(b)(2)(H)(1) to ensure that this organization has the financial capacity to meet its contractual obligations with respect to that contract.~~

~~(b)~~ Any failure of a plan to comply with the requirements of Section 1375.4 of the Code and any rules of this subarticle shall constitute grounds for disciplinary action against the plan. The Director may seek and employ ~~in~~ any combination ~~any~~ of remedies and enforcement procedures provided under the Act, to enforce Section 1375.4 of the Code and this subarticle.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

~~1300.75.4.8~~ 1300.75.4.6. Department Costs.

The Department's cost incurred in the administration of Section 1347.15 and 1375.4 of the Code shall come from amounts paid by plans, except specialized plans, pursuant to Section 1356 of the Code.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Sections 1374.15, 1356 and 1375.4, Health and Safety Code.